To: ❒ Department of Health Care Services
TPL/Personal Injury Unit
Fax: (916) 440-5668

OR

❒ Health Management Systems
WC Recovery Program
660 J Street, Suite 270
Sacramento, CA 95814

Date:_____

Mail: Original
File: Copy

POTENTIAL THIRD PARTY LIABILITY NOTIFICATION

1. Have you used, **or will you use,** Medi-Cal for your injury or illness? ..... ❒ Yes ❒ No

2. Have you filed, **or will you file,** a lawsuit or insurance claim? ..... ❒ Yes ❒ No

*If you answered **Yes** to one or both of the above questions, complete the following:*

3. Injury/illness occurred at: ❒ Home ❒ School ❒ On someone else's property ❒ Work ❒ Motor vehicle ❒ Other _____

Case name (first, middle, last)			**Date of injury or illness (*DATE MUST BE PROVIDED.*)**	
Address (number, street)	City	State	ZIP code	Social security number – –
Mailing address	City	State	ZIP code	Telephone number ( )

Injured Person(s):

Name	Date of Birth	County Code	Aid Code	Social Security Number (If not available, Medi-Cal or CIN)

4. Have you filed, **or will you file,** a lawsuit? ❒ Yes ❒ No If yes, please provide the following information:

Attorney name		Telephone number ( )	
Mailing address	City	State	ZIP code

5. Is there insurance (other than Medi-Cal/Medicare) **covering you or anyone else** for this injury/illness (auto, homeowners, premise liability, accident, health)? ❒ Yes ❒ No If yes, please provide the following information:

Insurance company		Telephone number ( )	
Mailing address	City	State	ZIP code
Claim adjuster	Claim/policy number	Policy holder	

WORK RELATED INJURY

Have you filed an application for Workers' Compensation benefits? ❒ Yes ❒ No

Employer at time of accident	Telephone number ( )	Workers' Compensation claim/case number	
Mailing address	City	State	ZIP code

DO NOT WRITE BELOW THIS LINE

COUNTY USE ONLY

Eligibility worker	Worker number	County	Telephone number ( )